Sexually Transmitted Disease Surveillance 1998

Division of STD Prevention

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
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The report is also available by Internet via the CDC home page at:
http://www.cdc.gov/nchstp/dstd/Stats_Trends/1998_Surv_Rpt_main_pg.htm

Foreword

"STDs are hidden epidemics of enormous health and economic consequence in the United States. They are hidden because many Americans are reluctant to address sexual health issues in an open way and because of the biologic and social characteristics of these diseases. All Americans have an interest in STD prevention because all communities are impacted by STDs and all individuals directly or indirectly pay for the costs of these diseases. STDs are public health problems that lack easy solutions because they are rooted in human behavior and fundamental societal problems. Indeed, there are many obstacles to effective prevention efforts. The first hurdle will be to confront the reluctance of American society to openly confront issues surrounding sexuality and STDs. Despite the barriers, there are existing individual- and community-based interventions that are effective and can be implemented immediately. That is why a multifaceted approach is necessary to both the individual and community levels.

To successfully prevent STDs, many stakeholders need to redefine their mission, refocus their efforts, modify how they deliver services, and accept new responsibilities. In this process, strong leadership, innovative thinking, partnerships, and adequate resources will be required. The additional investment required to effectively prevent STDs may be considerable, but it is negligible when compared with the likely return on the investment. The process of preventing STDs must be a collaborative one. No one agency, organization, or sector can effectively do it alone; all members of the community must do their part. A successful national initiative to confront and prevent STDs requires widespread public awareness and participation and bold national leadership from the highest levels"[1].

[1]Concluding statement from the Institute of Medicine's Summary Report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, National Academy Press, Washington, D.C., 1997, p.43.

Preface

Sexually Transmitted Disease Surveillance, 1998 presents statistics and trends of sexually transmitted diseases (STDs) in the United States through 1998. This annual publication is intended as a reference document for policy makers, program managers, health planners, researchers, and others who are concerned with the public health implications of these diseases. The figures and tables in this edition supersede those in earlier publications of these data.

The surveillance information in this report is based on the following sources of data: (1) case reports from the STD project areas; (2) prevalence data from the Regional Infertility Prevention Projects, STD project areas, the U.S. Job Corps, and Jail STD Prevalence Monitoring Projects; (3) sentinel surveillance of gonococcal antimicrobial resistance from the Gonococcal Isolate Surveillance Project; and (4) national sample surveys implemented by federal and private organizations.

The STD surveillance systems operated by state and local STD control programs, which provide the case report data, are the sources of most of the information in this publication. These systems are an integral part of program management at all levels of STD prevention and control in the United States.

Sexually Transmitted Disease Surveillance, 1998 consists of four parts. The **National Profile** contains figures that provide an overview of STD morbidity in the United States. The accompanying text identifies major findings and trends for selected STDs. The **Special Focus Profiles** contain figures and text describing STDs in selected subgroups and populations that are a focus of national and state prevention efforts. The **Detailed Tables** provide statistical information about STDs at the state, county, city, and national levels. The **Appendix** includes the sources and limitations of the data used to produce this report; Table A1 displays progress made toward Healthy People 2000 Priority Area 19, Objectives 19.1-19.8, on Sexually Transmitted Diseases; and Figures A1-A3 show progress made by states in converting from hardcopy aggregate reporting to electronic line-listed data submissions.

Selected figures and tables in this document include a reference point that is used to monitor progress toward some of the Healthy People 2000 (HP2000) national health status objectives for STDs[1]. The original HP2000 health status objectives were developed in 1989 and revised in 1995. The revisions are used as reference points in this edition of *Sexually Transmitted Disease Surveillance, 1998.*

Any comments and suggestions that would improve the usefulness of future publications are appreciated and should be sent to Director, Division of STD Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention, 1600 Clifton Road, Mailstop E-02, Atlanta, Georgia, 30333.

[1]Department of Health and Human Services. *Healthy People 2000: Midcourse Review and 1995 Revisions*. U.S. Department of Health and Human Services, Public Health Service, U.S. Government Printing Office, Washington, D.C., 1995.

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This report was prepared by the following staff members of the Division of STD Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention: Charles Akers, Susan Bradley, Jim Braxton, Sharon Clanton, Darlene Davis, Lyn Finelli, LaZetta Grier, Alesia Jester Harvey, Sharon Hixon, Kathleen Hutchins, Kristen Mertz, Debra Mosure, Raymond Ransom, LuEtta Schneider, Maya Sternberg, Emmett Swint, Susan Wang and Akbar Zaidi.

Dedication

We dedicate this volume to our colleague and friend, Russ Roegner. After 3 years as the Chief of the Statistics and Data Management Branch, Dr. Roegner is moving on to Washington, D.C. He has been an outstanding leader and dedicated member of the team producing this report. We wish him the best in the years to come.

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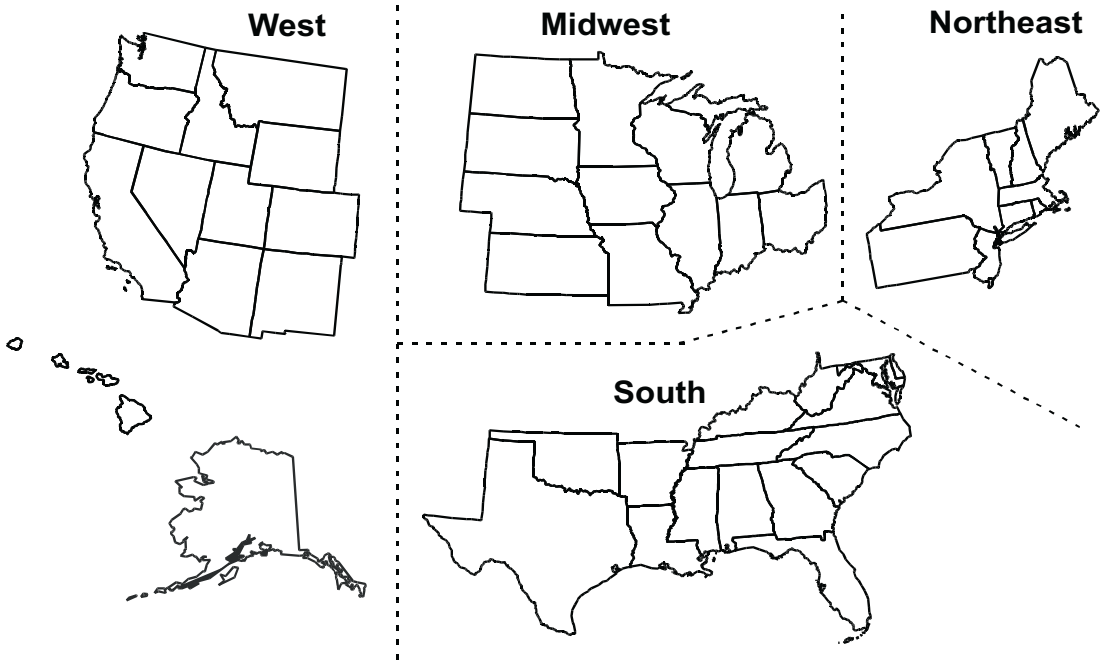

West	Midwest	South	Northeast
Alaska	Illinois	Alabama	Connecticut
Arizona	Indiana	Arkansas	Maine
California	Iowa	Delaware	Massachusetts
Colorado	Kansas	District of Columbia	New Hampshire
Hawaii	Michigan	Florida	New Jersey
Idaho	Minnesota	Georgia	New York
Montana	Missouri	Kentucky	Pennsylvania
Nevada	Nebraska	Louisiana	Rhode Island
New Mexico	North Dakota	Maryland	Vermont
Oregon	Ohio	Mississippi	
Utah	South Dakota	North Carolina	
Washington	Wisconsin	Oklahoma	
Wyoming		South Carolina	
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

National Overview of Sexually Transmitted Diseases, 1998

The logo on the cover of Sexually Transmitted Disease Surveillance, 1998 is a reminder of the multifaceted, national dimensions of the morbidity, mortality, and costs that result from sexually transmitted diseases (STDs) in the United States. It highlights the central role of STD prevention in improving women's and infants' health and in promoting HIV prevention. Organized collaboration among interested, committed public and private organizations is the key to reducing STDs and their related health burdens in our population. As noted in the recent report of the Institute of Medicine, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*[1], surveillance is a key component of our efforts to prevent and control these diseases.

This overview summarizes national surveillance data on the three diseases for which we have federally-funded control programs: chlamydia, gonorrhea, and syphilis. Several observations for 1998 are worthy of note.

In 1998, the reported number of cases of genital *Chlamydia trachomatis* infections was 607,602 a rate of 236.6 per 100,000 persons. In 1998, the overall reported rate for women (382.2 per 100,000) was nearly five times that for men (83.1). This difference in reported rates is attributable to screening strategies that focus on women because the severe sequelae of chlamydial infections accrue principally to women, and because these diseases are asymptomatic in the majority of infected women.

Using local, state, and federal resources, chlamydia prevention programs for screening of asymptomatic women have been established throughout the country. In 1998, state-specific chlamydia test positivity among women aged 15-24 years who were screened at family planning clinics ranged from 2.4% to 11.3%. These screening programs have consistently shown that the highest positivity of chlamydial infection in women is in adolescents. In addition, examination of chlamydial screening results for women aged 16-24 years entering the U.S. Job Corps shows that chlamydia is highly prevalent in these economically disadvantaged young women, with state-specific prevalence in 1998 ranging from 4.6% to 20.3%.

In parts of the United States where large-scale chlamydia programs have been instituted, prevalence of disease has generally declined. During 1988-1998, among 15- to 44-year-old women participating in the screening programs in Health and Human Services (HHS) Region X family planning clinics, chlamydia test positivity declined 60% (from 9.3% to 3.7%). During 1994-1998, among women under 45 years of age in Region III, positivity declined 6.4% (from 4.7% to 4.4%), and in Region VIII, positivity declined 10.3% (from 3.9% to 3.5%). Adjustment for changes in laboratory test method and sensitivity in 1998 may demonstrate larger declines in these and other HHS regions. For definition of HHS regions, see the Appendix.

Recent data on gonorrhea for 1994-1998 suggest that the annual decreases that have generally been evident since the national gonorrhea control program began in the mid-1970s may be lessening. In particular, the gonorrhea rate for 1998 (132.9 per 100,000 persons) was greater than the rate for 1997 (122.0). Although the 1997 gonorrhea rate was the lowest rate since national reporting

began, both it and the 1998 rate remain well above the revised Healthy People 2000 (HP2000) objective of 100.

With respect to gender, the gonorrhea rates for males and for females increased between 1997 and 1998. The gonorrhea rate for males increased from 124.9 to 133.7, and for females increased from 119.0 to 131.5. In contrast to earlier years, which generally exhibited decreasing age-specific rates for gonorrhea, most 5 year age categories had rates which increased between 1997 and 1998. These increases ranged from 6% to 14%. Only the rate for the oldest adults decreased slightly. Because men with gonorrhea are often symptomatic and seek medical care, trends in males are probably a good measure of trends in disease incidence. Trends in women are determined more by screening practices. Similar to chlamydia, rates of gonorrhea in women are particularly high in adolescents, with the highest rates in 15- to 19-year-olds.

With regard to antimicrobial resistance, a small proportion of *Neisseria gonorrhoeae* isolates tested through the Gonococcal Isolate Surveillance Project in 1998 (0.9%) demonstrated decreased susceptibility to ciprofloxacin, one of the currently recommended treatments for gonorrhea. However, resistance to ciprofloxacin continued to be rare (0.1%).

The 6,993 cases of primary and secondary (P&S) syphilis reported in 1998 were the fewest cases reported in the United States since 1958. The P&S syphilis rate of 2.6 per 100,000 persons (the lowest since national reporting began in 1941) is below the HP2000 objective of 4 per 100,000. Syphilis continues to be reported only in specific areas of the country. In 1998, approximately 78% of U.S. counties reported no cases of P&S syphilis. However, P&S syphilis rates exceeded 4 per 100,000 in 312 counties (10% of total counties). These 312 counties accounted for 76% of all reported P&S syphilis cases. Most notably, 91% (285 of 312) of these counties were in the South. In addition, 9 of the 12 states or outlying areas with P&S syphilis rates greater than 4 per 100,000 were located in the South. These data suggest that comprehensive syphilis prevention efforts focused in the South could markedly reduce the number of U.S. syphilis cases.

When STD statistics were examined by race or ethnicity, wide discrepancies in reported STD rates persisted between racial or ethnic groups. For example, the gonorrhea rate in blacks is approximately 30 times greater than the rate in whites. The rate of P&S syphilis in blacks is about 34 times that in whites; P&S syphilis in Hispanics is about 3 times that in whites. However, in 1998, of the 793 reported congenital syphilis cases with known race or ethnicity of the mother, blacks and Hispanics accounted for 89% of these reported cases, while accounting for only 23% of the female population, and 33% of all births. Race and ethnicity in the United States serve as risk markers that correlate with other, more fundamental determinants of health status such as socioeconomic status and access to good quality medical care. Reporting biases also undoubtedly play a role in race differentials, while not explaining them completely.

[1]Institute of Medicine. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, Committee on Prevention and Control of Sexually Transmitted Diseases, National Academy Press, Washington, D.C., 1997.